Shasta County Child Welfare Services
System Improvement Plan

October 1, 2004 – September 30, 2005

The Shasta County Departments of Social Services and Probation completed an in depth Self Assessment of current practice to assist the development of objectives for a Shasta County System Improvement Plan (SIP) that will lead to compliance with state and federal goals for the safety, permanence and well being of abused and neglected children. This was part of the California Child and Family Services Review (C-CFSR), a result of Assembly Bill 636 that provided a framework for development of a new outcome-based review as part of California's Program Improvement Plan to become compliant with the federal Adoptions and Safe Families Act (ASFA). The Self Assessment was the County's opportunity to explore how local program operations and other systemic factors affect measured outcomes. Community partners and County staff critically assessed how we currently work with children and families in the Child Welfare and Juvenile Probation disciplines. Careful attention was given to Child Welfare Redesign goals that call for a greater community involvement in the prevention and intervention of child maltreatment through a strengths based approach.

A strength identified in Shasta County is the way the current system consults and coordinates regularly with its community partners, via the Collaborative Planning Groups (i.e., Children's Policy Council, Children's Cabinet, Interagency Children's Mid-managers Team, etc.) and on a case basis through a variety of multi-discipline review teams that look at every critical decision that is made to address the needs of the families and the children in the child welfare system. The County and its community partners utilize the committees to identify shared expectations, responsibilities and risks.

For the Self Assessment and SIP process Shasta County Social Services and Probation Departments sought a diverse representation and maximum community input. The County began with a series of four community meetings at which California's Child Welfare Redesign was presented to over 200 interested individuals representing city and County government, law enforcement, education, the courts, parents, youth, local community-based and faith-based organizations and individual interested community members. From that series of community forums, eighty individuals volunteered to participate on Shasta County's Redesign Planning and Implementation Team.

The Redesign Team met twice: in January and April of this year. Two subcommittees of approximately 30 individuals each were formed by members of the Redesign Team to specifically work on the Self Assessment and the SIP. The Self Assessment and SIP Teams sought input from, and reported to, the Redesign Team. Throughout all Team meetings, special attention has been given to the 40 Developmental Assets approach as the underlying strengths based philosophy to guide the Self Assessment and design of the SIP. The Self Assessment team met as a team an additional two times: in March and May, and worked in subcommittees that specifically addressed the five elements of the SAP: I) Demographic Profile and Outcomes Data, II) Public Agency Characteristics, III) Systemic Factors, IV) County-wide Primary Prevention Strategies, and V) Summary Assessment. The SIP Team convened in June to prioritize needs and gaps identified in the Self Assessment to begin to formulate Shasta County's SIP. Four SIP

subcommittees were formed that specifically addressed the safety outcomes that were identified as areas needing improvement in the Self Assessment: I) Recurrence of Maltreatment (1A and 1B), II) Rate of Recurrence of Abuse and/or Neglect in Homes Where Children Were Not Removed (2A), III) Child Abuse/Neglect Referrals with a Timely Response (2B 10-Day), and IV) Timely Social Worker Visits With Children (2C). All SIP subcommittees came back together in August to review the recommended goals and strategies.

The County departments of Probation and Social Services received extensive support from Mental Health, Public Health, Alcohol and Drug, Housing and Community Action, County Administrative Office, and other government and community-based organizations and community representatives in completing the Shasta County Self Assessment and the SIP.

I) Self Assessment Participants

Ron Abke Shasta County DSS-CFS
Melinda Adams Therapist
Sheila Adams Shasta County DSS-CFS
Celeste Adams-Bell City of Redding - Parks & Rec
Carla Alexander No. Valley Catholic Social Services
Karen Alexander Shasta County Office of Education
Rick Alford Shasta County DSS-CFS
Art Alvarado Shasta County Probation Department
Linda Barba Shasta County DSS-Eligibility
Don Barber Enterprise Elementary School District
John Barry Shasta County Public Health
Betty Beaver Shasta County Office of Education
Janet Belen Shasta County DSS-CFS
Muffy Berryhill First 5 Shasta
Staci Bertagna Plus One Mentors
Cindy Bither-Bradley Shasta County Mental Health
Deeda Blair-LeCoe Shasta County DSS-CFS
Garry Blasingame New Directions to Hope
Nancy Bolen Shasta County DSS-CFS
Doreen Bradshaw Grassroots Community Board
Kathy Bradshaw Foster Parent
Kerry Bradshaw
Fran Brady Shasta County DSS-CalWorks
Johanna Brazil Shasta County DSS-CFS
Celeste Buckley Shasta County - County Administrative Office
Michael Burke Plus One Mentors
Colleen Cambra Hillcrest Springs FFA
Jan Carter Hillcrest Springs FFA
Laura Carter Hillcrest Springs FFA
Amy Clark Fost/Adopt Parent
Carla Clark Shasta Head Start
Kristi Claycamp Shasta County DSS-CFS
Vickie Lynn Cochran
Michelle Corder
Roberto D'Amico Family Service Agency
Linda Dickerson Shasta County Women's Refuge
Karen Dillard Shasta County DSS-CFS
Lynn Dorroh ACORN
Karin Dowling Health Improvement Partnership of Shasta
Jacqueline Dunn Shasta County DSS-CFS
Kim Elliott Shasta County DSS-CFS
Michael Elterman Shasta FICS
Michelle Erickson Anderson Partnership for Healthy Children
Angela Fitzgerald Superior Court of Ca, Shasta
Susan Fresz Shasta Community Health Center
Carolyn Furnish Therapist
Betty Futrell Shasta County Child Abuse Prevention Coordinating Council
Linda Gibson Far Northern Regional Center
Bonnie Gordon Shasta County DSS-CFS
Chris Grabe Shasta County DSS-CFS
Bobbie Gray No. Valley Catholic Social Service
Dr. Beth Greenwood Shasta Community Health Center
Steve Grimm Shasta County DSS- CalWorks
Bobbie Groves Shasta County Office of Education
Susan Hacking Shasta County Mental Health - Alcohol & Drug
Melissa Harris Family Service Agency
Susan Harrison Shasta County DSS-CFS
Bob Helmbold Shasta County DSS-CFS
Holly Hetzel Shasta County Drug Endangered Children Program
Pamela Hewlett Shasta County DSS-CFS
Bonnie Hill Shingletown Medical Center
Julie Hope Shasta County - Co. Admin. Office
Robert Hughes Remi Vista
Kathy Hupal Shasta County DSS-CFS
Belinda Hutchings Shasta County Public Health
Jeannie Jacobs Shasta County Office of Education
Margaret Jensen ACORN
Nelda Johnson Shasta County DSS-CFS
Kathy Jones Shasta County Mental Health
Ketu Jones HART Center
Lynne Jones Shasta County Mental Health
Lori Juszak Grassroots for Kids
Colleen Kinslow Bethel Church
Kathy Klein Intermountain Community Center
Karen Krumenacker Shasta County Public Health
Judy Kupsky Shasta County DSS-CFS

Linda Lafferty Enterprise Elementary School District - Healthy Start
Bob LeCoe Shasta County DSS-CFS
Faye Lee Shasta County DSS-CalWorks
Larry Lees Shasta County Housing Authority
Karin Lightfoot Shasta County Public Health
Rod Lindsay Anderson Union High School District
Kristen Logan Shasta County Public Health
Isaac Lowe Community Advocate
Betsy Madison Shasta County Office of Education
Randee Maeda Shasta County DSS-CFS
Gwen Mansbridge Shasta County Public Health
Julie Marvin Shasta County Child Abuse Prevention Coordinating Council
Eddie McAllister Shasta County Public Health
Barbara McKend Shasta County DSS
Marta McKenzie Shasta County Public Health
Ugo Melloni Foster Parent
Charles Menoher Youth Violence Council
Michelle Meuser Shasta County Women's Refuge
Amber Middleton Shasta County DSS-CFS
Jill Mindus Shasta County DSS
Chris Moats Family Service Agency
Beverly Moreno Grassroots for Kids
Frank Moreno Grassroots for Kids
Patrick Moriarty Shasta County Public Health
Ann Murphy Shasta Community Health Center
Gina Muse Shasta County DSS-CFS
Kimberly Niemer City of Redding - Community Services Department
Melissa Olson Shasta County DSS-CFS
Christine O'Neill Shasta County DSS-CFS
Gracious Palmer Shasta Lake Planning Commission
Shirley Park Shasta County DSS-CFS
Linda Parks Shasta County DSS-CalWorks
Phil Paulsen Shasta County DSS
Dena Persell Youth & Family FFA
Tracy Ray Cascade & Happy Valley Special Education
Dana Reginato Enterprise Elementary School District
Angela Richardson Shasta County DSS-CFS
Julia Rocafort Shasta FICS
Victoria Ross-Clark Shasta County DSS-CFS
Jody Rowland Shasta County DSS-CFS
Richard Ryan Shasta County DSS-CFS
Laura Scott Shasta County DSS-CFS
Brad Seiser Shasta County DSS-CFS
Gregory Shaffer
Henson Shawn Shasta Head Start
Loretta Shea Redding Medical Center Hospital
Nancy Shifflet Shasta County Public Health
Del Skillman Shasta County DSS
Renee Souza Parent Leadership Task Force
Jeanne Spurr New Directions to Hope
Lori Steele Shasta County Mental Health
Jerry Stenehjem Shasta County DSS-CFS
Janet Stortz Shasta County DSS-CFS
Ann Stow Shasta County Probation Department
Tom Taylor Shasta County DSS-CFS
Percy Tejada Tribal Government
Kathy Thompson Shasta County Office of Education
Jantina Thompsoon Shasta County DSS-CFS
Sara Till Shasta County Probation Department
John Tillery Remi Vista
Linda Vaught Shasta County DSS-CFS
Maria Velasquez True North
Venessa Vidovich Shasta County Public Health
Maxine Wayda Shasta County Mental Health
Andrea Wemette Youth & Family FFA
Lori Westlake Foster Parent
Carol Whitmer Shasta County Office of Education
Jane Willson-Armstrong Shasta County DSS-CFS
Gregory Winters

II) System Improvement Plan Participants

Sheila Adams Shasta County DSS-CFS
Carla Alexander No. Valley Catholic Social Services
Rick Alford Shasta County DSS-CFS
Art Alvarado Shasta County Probation Department
John Barry Shasta County Public Health
Melissa Berry, Parent
Cindy Bither-Bradley Shasta County Mental Health
Garry Blasingame New Directions to Hope
Nancy Bolen Shasta County DSS-CFS
Celeste Buckley Shasta County - County Administrative Office
Colleen Cambra Hillcrest Springs FFA
Jan Carter Hillcrest Springs FFA
Brenda Chesnut, Grandparent
Kristina Conner Professional Peace Officers Association
Gilbert dela Feunte Shasta County DSS-CFS
Marty Davis, Remi Vista
Linda Dickerson Shasta County Women's Refuge
Karin Dowling Health Improvement Partnership of Shasta
Susan Fresz Shasta Community Health Center
Carolyn Furnish Therapist
Betty Futrell Shasta County Child Abuse Prevention Coordinating Council
Matt Grigsby Shasta County DSS-CFS
Susan Hacking Shasta County Mental Health - Alcohol & Drug
Susan Harrison Shasta County DSS-CFS
Lisa Heffley Shasta County DSS-CFS
Bob Helmbold Shasta County DSS-CFS
Pamela Hewlett Shasta County DSS-CFS
Kathy Hupal Shasta County DSS-CFS
Sher Huss Shasta County DSS-CFS
Belinda Hutchings Shasta County Public Health
Jeannie Jacobs Shasta County Office of Education
Lynne Jones Shasta County Mental Health

Janet King Shasta County DSS-CFS
Judy Kupsky Shasta County DSS-CFS
Raelene MacDowell, Foster Parent Liaison
Carol Mapel Shasta County Employee Association
Barbara McKend Shasta County DSS
Charles Menoher Youth Violence Council
Amber Middleton Shasta County DSS-CFS
Kim Misner Shasta County DSS-CFS
Kim Montgomery Shasta County DSS-CFS
Beverly Moreno Grassroots for Kids
Frank Moreno Grassroots for Kids
Patrick Moriarty Shasta County Public Health
Gina Muse Shasta County DSS-CFS
Kim Myers Shasta County DSS-CFS
Melissa Olson Shasta County DSS-CFS
Christine O'Neill Shasta County DSS-CFS
Linda Parks Shasta County DSS-CalWorks
Cindi Peck Shasta County DSS-CFS
Dena Persell Youth & Family FFA
Bonnie Rightmier Shasta County DSS-CFS
Dave Ritchie United Public Employees of CA, Local 792
Richard Ryan Shasta County DSS-CFS
Brad Seiser Shasta County DSS-CFS
Hemal Sharifzada CYC
John Simmons Shasta County DSS-CFS
Jeanne Spurr New Directions to Hope
Lori Steele Shasta County Mental Health
Monique Taylor, Parent, Parent Partner
Tom Taylor Shasta County DSS-CFS
Percy Tejada Tribal Government
Jantina Thompson Shasta County DSS-CFS
Kathy Thompson Shasta County Office of Ed
Sara Till Shasta County Probation Department
Venessa Vidovich Shasta County Public Health
Maxine Wayda Shasta County Mental Health
John Zeis Shasta County Superior Court

Several community meetings were held throughout the Self Assessment process to collect qualitative data to analyze practices associated with customer service, family assessment, service delivery, and case planning. Community discussions were held that explored current Children and Family Services (CFS) practices and elicited perceptions of the effectiveness of those services from the community. Major concerns identified were the lack of early intervention prevention services for families and the lack of use of a standardized assessment tool. Currently in Shasta County there are not as many services as we would like that are targeted to families with key risk factors for child maltreatment. Together County and community partners brainstormed areas needing improvements. Areas identified where enhancements could lead to improved safety and well being of children and families included but were not limited to:

- Confidentiality barriers to partnerships
- Parent and family interventions that assess and engage the family from a strengths based perspective
- Early intervention to help families keep children safely at home
- Transportation in rural areas of the County
- More funding
- A resource guide of partnerships and services and/or a clearinghouse
- A process for updating all staff about the large number of resources available
- Child and family interventions that engage youth
- Partnerships in the community, such as neighborhoods, faith-based organizations and teens

In an attempt to elicit information from birth parents that have active cases with CFS, CFS conducted a brief four-question telephone survey to find out about the perceived effectiveness of the services they received. Out of a total sample of 78 birth parents, CFS was able to contact and get responses from 15%. Over a period of approximately three weeks, multiple attempts were made to reach each of the parents in the sample with the following results: 27% where there was no answer, 22% where the number had been disconnected, 14% that the requested persons were not at home, and 22% wrong numbers. Of the 15% of birth parents reached and interviewed:

- When asked about what services could have been provided that would have prevented their

child(ren) from being removed: 67% responded that nothing could have prevented their child(ren) from being removed from them; 25% said that parental education, mentoring or support groups would have been helpful; and 8% said that assistance for stable housing would have helped them.

- When asked about which services had been helpful in reunifying or attempting to reunify with their children: 50% chose substance abuse programs; 33% chose parent-child visitation; 33% chose individual or family counseling; 25% chose parental education, mentoring or support groups; 8% chose assistance for stable housing; and 17% chose other.
- When asked whether their input was listened to: 17% said always, 25% said most of the time, 50% said sometimes, and 8% said never.
- When asked whether they know who to contact if they have opinions, ideas or concerns regarding their local child welfare or foster care agency: 67% said yes and 33% said no.

Shasta County CFS is open to the peer quality case review process and collaboration. This could be particularly helpful in areas where the County is looking at ways to strengthen existing programs. Having staff from other counties, with successful programs to come in and assess our County's programs could provide inspiration for change. Some areas identified that may fit this approach include:

- Alternative Dispute Resolution – to address the current issues around contested hearings.
- Family Decision Making – to address case planning and involvement of extended family in a support to the family and children in the system.
- Fiscal Alternatives – to address the leveraging of funds and full utilization of available allocations within legal constrains.

The Shasta County team has chosen to utilize the Search Institute's 40 Developmental Asset approach as a tool for implementing a strengths-based approach to its redesigned Child Welfare Services system. Based on the Self Assessment and community recommendations the following areas were targeted for the first year of the Shasta County SIP:

- Decreasing the Recurrence of Maltreatment (1A and 1B) and decreasing the Rate of Recurrence of Abuse and/or Neglect in Homes Where Children Were not Removed (2A) through development and implementation of a joint CFS/Community Differential Response protocol.

- Decreasing the Recurrence of Maltreatment (1A and 1B), Decreasing the Rate of Foster Care Re-Entry (3F and 3G), and improving Systemic Factor B: Case Review – Parent and Youth Participation in Case Planning through joint CFS/Community Family/Team meetings.

- Increasing the percentage of Child Abuse/Neglect Referrals with a Timely 10-Day Response (2B) through development and implementation of standard agency guidelines/expectations and piloting of geographical referral assignment.

- Increasing the percentage of Timely Social Worker Visits with Children (2C) through development and implementation of standard agency guidelines/expectations and institutionalization of an effective quality assurance process.

Outcome/Systemic Factor:
Recurrence of Maltreatment (1A and 1B)
Rate of Recurrence of Abuse and/or Neglect in Homes Where Children Were Not Removed (2A)

County's Current Performance:
Federal: Of all children with a substantiated allegation within the first six months of the 12-month study period, what percent had another substantiated allegation within six months?

1A. Percent recurrence of maltreatment (Fed)	
12-month study period	
01/01/03-12/31/03	10.0%
10/01/02-09/30/03	10.6%
07/01/02-06/30/03	10.0%

State: Of all children with a substantiated referral during the 12-month study period, what percent had a subsequent substantiated referral within 12 months?

1B. Percent recurrence of maltreatment within 12 months	
12-month study period	
01/01/02-12/31/02	15.6%
10/01/01-09/30/02	14.3%
07/01/01-06/30/02	17.1%

State: Of all children with a **first** substantiated referral during the 12-month study period, what percent had a subsequent substantiated referral within 12 months?

1B. Percent recurrence of maltreatment within 12 months after first substantiated allegation	
12-month study period	
01/01/02-12/31/02	13.7%
10/01/01-09/30/02	13.4%
07/01/01-06/30/02	14.5%

State: Of all the children with allegation (inconclusive or substantiated) during the 12-month study period who were not removed, what percent had a subsequent substantiated allegation within 12 months?

2A. Percent rate of recurrence of abuse/neglect in homes where children were not removed	
12-month study period	
01/01/02-12/31/02	9.2%
10/01/01-09/30/02	8.3%
07/01/01-06/30/02	10.6%

Improvement Goal 1.0 Improve the level of consistency in assignment of referrals to the three tracks.

Strategy 1. 1 Utilize a standardized assessment tool for assigning new referrals to the appropriate track.	**Strategy Rationale:** Consistent determinations will help all service providers (Children and Family Services and community based organizations) have a common understanding and expectation of what risk factors will rise to the level requiring a CFS investigation.

Milestone	Timeframe	Assigned to
1.1.1 Assessment tools (that meet state requirements and specifically the needs for differential response) identified and researched.	3 months (12/31/04)	Children and Family Services Core Differential Response Team, Graduate Student, Health Improvement Partnership, Community Based Organizations.
1.1.2 Assessment tool selected.	4 months (1/31/05)	Children and Family Services Core Differential Response Team.
1.1.3 Staff trained in utilization of the Assessment tool.	5 months (2/28/05)	Intake Supervisors, Staff Development Supervisor, Health Improvement Partnership, Vender.
1.1.4 Assessment tool implemented and evaluated.	6 – 12 months (3/31/05 – 9/30/05)	Intake Supervisors, Program Managers.

Improvement Goal 2.0 Reduce the recurrence of abuse/neglect as measured by the number of subsequent substantiated/inconclusive re-referrals occurring within 12 months.

Strategy 2.1 Engage families of new referrals that would otherwise be evaluated out and receive no follow up response or referral to services.	**Strategy Rationale** Early intervention with referred families will result in a reduction of abuse/neglect in the future because minor problems will be addressed before they become major ones.

Milestone	**2.1.1** Focus group held. Criteria determined to consider when assigning referrals for a Differential Response.	**Timeframe**	2 months (11/30/04)	**Assigned to**	Intake Supervisor, Program Manger, Social Workers, Parents, Health Improvement Partnership, Community Based Organization Partners.
	2.1.2 Training provided to telephone screeners and/or other workers assigned to review referrals and screen in referrals for a Differential Response.		4 months (1/31/05)		Intake Supervisors, Staff Development Supervisor
	2.1.3 Existing mechanisms for communicating with identified families researched and studied.		6 months (3/31/05)		Children and Family Services / Community Differential Response Team
	2.1.4 Mechanism for communicating with identified families chosen and developed. Ongoing effectiveness of the mechanism evaluated.		7 – 12 months (4/30/05 – 9/30/05)		Intake Supervisor, Program Manger, Social Workers, Parents, Health Improvement Partnership, Community Based Organization Partners.
Strategy 2. 2 Differential Response families requesting services will be assessed and referred to relevant community based organizations for resources and services.		**Strategy Rationale** Assessment will insure more appropriate referrals.			
Milestone	**2.2.1** Community based organizations to provide assessment and services are identified and coordinated.	**Timeframe**	3 months (12/31/04)	**Assigned to**	Shasta County Child Abuse Prevention Coordinating Council, Health Improvement Partnership, Community Partners, Parents, Intake Supervisor, Social Workers, Program Manager, Graduate Student.

	2.2.2 Assessment tool selected and referral procedure developed that is to be used by community based organizations.		6 months (3/31/05)		Shasta County Child Abuse Prevention Coordinating Council, Health Improvement Partnership, Community Partners, Parents, Intake Supervisor, Social Workers, Program Manager.
	2.2.3 Communication mechanism between clients, Children and Family Services and community based organizations is developed in order to provide seamless services and to track effectiveness of services.		6 – 12 months (3/31/05 – 9/30/05)		Shasta County Child Abuse Prevention Coordinating Council, Health Improvement Partnership, Community Partners, Parents, Intake Supervisor, Social Workers, Program Manager, County Counsel.
Strategy 2.3 Investigate and develop funding sources.			**Strategy Rationale** Funding and incentives are needed for community based organizations to provide resources and services to the clients.		
Milestone	**2.3.1** Funding Team of program and fiscal specialists created (including interested community based organizations and Interagency Children and Family Services.)	**Timeframe**	1 – 2 months (10/31/04 – 11/30/04)	**Assigned to**	Interagency Fiscal Mid-Managers, Children's Policy Council, Health Improvement Partnership, Community Partners, Interagency Children and Family Services (Supervisors, Program Managers). .
	2.3.2 Research conducted on how other counties and states fund services/resources.		3 – 6 months (12/31/04 – 3/31/05)		Interagency Fiscal Mid-Managers, Children's Policy Council, Health Improvement Partnership, Community Partners, Interagency Children and Family Services (Supervisors, Program Managers).

	2.3.3 Plans developed and implemented for obtaining funds for agency and community based organizations.		7 – 12 months (4/30/05 – 9/30/05)		Interagency Fiscal Mid-Managers, Children's Policy Council, Health Improvement Partnership, Community Partners, Interagency Children and Family Services (Supervisors, Program Managers).

Discuss changes in identified systemic factors needed to further support the improvement goals.
Development of agreements between agencies and community based organizations that provide guidelines for implementation, working relationships, and confidentiality. Development of a referral form, release and exchange of information form, and reporting tool for all Differential Response referrals. Funding for caseload levels to permit the assignment of referrals to the three tracks. Awareness of cultural issues and cultural diversity must be taken into consideration and, if appropriate, incorporated into every decision making process.

Describe educational/training needs (including technical assistance) to achieve the improvement goals.
Training in fairness and equity as well as in the use of the assessment tool and agency expectations will increase consistency in how referrals are assigned to the tracks. Cross training of County and community staff on procedures and guidelines for handling differential responses and confidentiality expectations. Training in working with community partners for Social Workers. Training for community partners.

Identify roles of the other partners in achieving the improvement goals.
Community partners will share the responsibility for follow up and provision of services for families that would otherwise be screened out as not meeting the legal requirements for an investigation and/or services as a result of abuse and neglect. Training of other partner staff on mandated reporting, risk factors, identifying abuse and neglect will help Children and Family Services staff feel comfortable having referrals responded to by non Children and Family Services staff. Development of Children and Family Services intervention specific resource guide for intake referrals. Development of resource guide for families. Together the community based providers and the agency need to work through communication and confidentiality concerns.

Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals.
A Child Welfare Services/Case Management System (CWS/CMS) tracking system for Differential Response with appropriate funding for the amount of work involved. Funding to purchase and support an Assessment Tool such as Structured Decision Making. Enhanced and flexible funding to support the early intervention activities to be referred. Regulatory/law changes to support the implementation of Differential Response and the sharing of information, training, and resources.

Outcome/Systemic Factor:

Recurrence of Maltreatment (1A and 1B)
Rate of Foster Care Re-Entry (3F and 3G)
Systemic Factor B: Case Review – Parent and Youth Participation in Case Planning.

County's Current Performance:

Federal: Of all children with a substantiated allegation within the first six months of the 12-month study period, what percent had another substantiated allegation within six months?

1A. Percent recurrence of maltreatment (Fed)	
12-month study period	
01/01/03-12/31/03 (Revised)	10.0%
10/01/02-09/30/03	10.6%
07/01/02-06/30/03	10.0%

State: Of all children with a substantiated referral during the 12-month study period, what percent had a subsequent substantiated referral within 12 months?

1B. Percent recurrence of maltreatment within 12 months	
12-month study period	
01/01/02-12/31/02	15.6%
10/01/01-09/30/02	14.3%
07/01/01-06/30/02	17.1%

State: Of all children with a ***first*** substantiated referral during the 12-month study period, what percent had a subsequent substantiated referral within 12 months?

1B. Percent recurrence of maltreatment within 12 months after first substantiated allegation	
12-month study period	
01/01/02-12/31/02	13.7%
10/01/01-09/30/02	13.4%
07/01/01-06/30/02	14.5%

Federal: For all children who entered child welfare supervised foster care during the 12-month study period, what percent were subsequent entries within 12 months of a prior exit?

3F. Percent of admissions who are re-entries (Fed)	
12-month study period	
01/01/03-12/31/03	10.3%
10/01/02-09/30/03	10.4%
07/01/02-06/30/03	9.8%

State: For all children who entered child welfare supervised foster care for the first time (and stayed at least five days) during the 12 month study period and were reunified within 12 months of entry, what percent re-entered foster care within 12 months of reunification?

3G. Percent who re-entered within 12 months of reunification (entry cohort reunified within 12 months)	
12-month study period	
01/01/01-12/31/01	14.6%
10/01/00-09/30/01	19.6%
07/01/00-06/30/01	20.2%

Improvement Goal 1.0 Increase family and community involvement with families involved with or at risk of becoming involved with the child welfare or juvenile probation systems by the tailoring of services to a family's individual needs and strengths.

Strategy 1. 1 Develop and communicate a culturally and ethnically appropriate agency wide policy regarding family involvement in the case planning process and the use of strength-based Family/Team meetings to increase parent/youth participation in case planning.	**Strategy Rationale:** Family/Team meetings lead to more involvement of "family" members, community and personal support people and services that can help the family change so that further incidents of abuse/neglect are minimized. Family/Team meetings affect not only recurrence of maltreatment but also stability and permanence. A culturally and ethnically appropriate guideline is needed as there is currently limited/inconsistent use of this practice in most units.

Milestone		Timeframe	Assigned to
	1.1.1 Focus groups held. Information collected on types of Family/Team meetings, what other counties are doing, effectiveness of these meetings, what parents and youth would like to see, and what seems to be currently working. Model developed, where the family drives Family/Team meetings, and policy drafted for Family/Team meetings in Shasta County.	3 months (12/31/04)	Supervisors, Social Workers, LIFTT representative, Interagency Partner representatives (Probation, MH, PH, A&D, etc.), Parent, Foster Parent, Youth, Health Improvement Partnership, Community representatives, Analyst.
	1.1.2 Family/Team meeting forms developed. Strength-based forms to be used in Family/Team meetings developed.	4 months (1/31/05)	Supervisors, Social Workers, LIFTT representative, Interagency Partner representatives (Probation, MH, PH, A&D, etc.), Parent, Foster Parent, Youth, Health Improvement Partnership, Community representatives, Analyst.
	1.1.3 Policy, tools and forms reviewed with Program Managers, Supervisors, revised and approved.	5 months (2/28/05)	Supervisors and Program Managers
	1.1.4 Policy presented to staff (including community and interagency partners, and parent/foster parent/youth partners) for discussion and implementation.	6 months (3/31/05)	Staff Development Supervisor, Unit Supervisors, Health Improvement Partnership.

Strategy 1. 2 All staff (including Community and Interagency Partners, and Parent/Foster Parent/Youth partners) will receive training in Family/Team meetings and family focused case planning that supports involvement of parents and youth in the case planning process.	**Strategy Rationale** Family-focused planning is an evidence-based practice that improves outcomes for children and families and Family/Team meetings are an important part of that practice. Staff are hesitant about and inconsistent in their use of Family/Team meetings and involvement of families in the case planning process.

Milestone		Timeframe	Assigned to
	1.2.1. Explore available training and work with Regional Training Academy (RTA) to develop strengths-based, family focused training that includes Family/Team meetings.	2 months (11/30/04)	Staff Development Supervisor
	1.2.2 Program Manager and Supervisors receive training/refresher on transfer of learning.	3 to 4 months (12/31/04 – 1/31/05)	Staff Development Supervisor to arrange
	1.2.3 All staff receive training on strengths-based, family focused practice and Family/Team meetings.	5 to 12 months (2/28/05 – 9/30/05)	Staff Development Supervisor to arrange
	1.2.4 Supervisors report on: – how they are monitoring the transfer of learning of their workers – how workers are doing with changing practice.	6 to 12 months (3/31/05 – 9/30/05)	Supervisors, Program Managers

Strategy 1. 3 Measure how many Family/Team meetings are being done and how effective they are.	**Strategy Rationale** We need to be able to compare the increase in Family/Team meetings with our recurrence of maltreatment statistics to see if this strategy is effective.

Milestone		Timeframe	Assigned to
	1.3.1 Surveys to measure use of Family/Team meetings for staff, parents, youth, and community agencies; and effectiveness of meetings are developed.	1 month (10/31/04)	Social Worker, Supervisor, Parents, Youth Care Providers, Analyst to write. Supervisors and Program Managers to approve.
	1.3.2 Survey conducted among staff, families, and community agencies and results presented at Supervisor's meeting.	3 months (12/31/04)	Supervisors
	1.3.3 Establish a method of collecting information on ongoing/current use of Family/Team meetings, family's point of view, and effectiveness.	3 months (12/31/04)	Social Worker, Supervisors, Analyst
	1.3.4 Data on use of Family/Team meetings collected and reported to Program Managers quarterly.	3, 6, 9 and 12 months (12/31/04, 3/31/05, 6/30/05, 9/30/05)	Supervisors, Analyst

Strategy 1.4 Investigate and develop funding sources.	**Strategy Rationale** Funding and incentives are needed for community based organizations to provide resources and services to the clients.

Milestone	**1.4.1** Funding Team of program and fiscal specialists created (including interested community based organizations and Interagency Children and Family Services.)	**Timeframe**	1 – 2 months (10/31/04 – 11/30/04)	**Assigned to**	Interagency Fiscal Mid-Managers, Children's Policy Council, Health Improvement Partnership, Community Partners, Interagency Children and Family Services (Supervisors, Program Managers). .
	1.4.2 Research conducted on how other counties and states fund services/resources.		3 – 6 months (12/31/04 – 3/31/05)		Interagency Fiscal Mid-Managers, Children's Policy Council, Health Improvement Partnership, Community Partners, Interagency Children and Family Services (Supervisors, Program Managers). .
	1.4.3 Plans developed and implemented for obtaining funds for agency and community based organizations.		7 – 12 months (4/30/05 – 9/30/05)		Interagency Fiscal Mid-Managers, Children's Policy Council, Health Improvement Partnership, Community Partners, Interagency Children and Family Services (Supervisors, Program Managers).

Discuss changes in identified systemic factors needed to further support the improvement goals.
We need a good Quality Control/Assurance system. We need more funding for community agencies to offer more individualized services. Caseloads consistent with SB2030 recommendations are necessary to afford Social Workers time for an effective implementation of the labor intensive Family/Team meeting process. Awareness of cultural issues and cultural diversity must be taken into consideration and, if appropriate, incorporated into every decision making process.

Describe educational/training needs (including technical assistance) to achieve the improvement goals.
Community partners will have to have solid training in identifying families that need to be referred back to CFS. Training will be needed in conducting Family/Team meetings for Social Workers and community partners. On the policy level the agency must make a commitment to strengths-based work.

Identify roles of the other partners in achieving the improvement goals.
Community partners and CFS must be willing and able to work together on a pilot project even if there is not additional funding available. Together we need to work through communication and confidentiality issues.

Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals.
Flexible funding will be necessary to spread the pilot project. Funding for additional Social Workers and support staff will be needed. UC Davis trainings should be open to all community partners.

Outcome/Systemic Factor: Child Abuse/Neglect Referrals with a Timely 10-Day Response (2B)

County's Current Performance:

2B. Percent of child abuse/neglect referrals with a timely response	**10-Day Response Compliance**
Q4 2003	73.3%
Q3 2003	79.6%
Q2 2003	78.1%

Improvement Goal 1.0: Increase the percentage of timely Supervisor assignment and timely Social Worker response to and documentation in CWS/CMS of child abuse/neglect 10-Day referrals. Increase County performance to 90% compliance by the end of the first year of the implementation of the System Improvement Plan.

Strategy 1.1: Evaluate the current 10-Day referral assignment process to identify where referrals are getting held up.	**Strategy Rationale:** Social Workers not getting 10-Day referrals assigned to them in a timely manner directly contributes to their ability to meet compliance requirements.

Milestone	Timeframe	Assigned to
1.1.1 Survey developed to capture when referrals are received by CFS, when they are received by the Intake Supervisors and why, and when they are received by the Intake Social Workers and why.	1 month (10/31/04)	Intake Supervisors, Phone Screeners, Analyst
1.1.2 Survey developed in 1.1.1 used to track the assignment process of all referrals for a 2 month time period.	3 months (12/31/04)	Intake Supervisors, Phone Screeners
1.1.3 Survey results analyzed for trends and guidelines developed for the timely assignment of referrals to Social Workers.	5 months (2/28/05)	Intake Supervisors, Line Social Workers, Staff Development Supervisor, Analyst

Strategy 1. 2: Develop and institutionalize standard agency guidelines and expectations for the practice of making timely contacts in 10 day referrals and documenting contact information (including attempted contacts) into CWS/CMS.		**Strategy Rationale:** The accessibility of written guidelines and standard agency expectations will help workers deal with conflicting priorities.	
Milestone	**Timeframe**	**Assigned to**	
1.2.1 Standard agency guidelines and expectations for the practice of *timely* making and documenting 10-Day referrals are developed.	3 months (12/31/04)	Supervisors, Analyst	
1.2.2 Guidelines reviewed at Supervisors meeting, revised, and accepted by Program Managers.	4 months (1/31/05)	Supervisors, Program Managers	
1.2.3 Social Worker trained on guidelines and standard agency expectations.	5 months (2/28/05)	Staff Development Supervisor	
1.2.4 Intake Supervisors supervision time used to help Social Workers learn to use guidelines and list of standardized expectations to prioritize workload.	6 – 12 months (3/31/05 - 9/30/05)	Intake Supervisors	

Strategy 1. 3: Pilot geographical referral assignment.		**Strategy Rationale:** Geographically assigning referrals to Social Workers should result in an increased timely assignment of referrals to Social Workers that should increase the percentage of timely response.	
Milestone	**Timeframe**	**Assigned to**	
1.3.1 3 Intake Social Workers assigned to 3 different geographic areas (e.g., North County, South County, and Foothills). Pilot the assignment all referrals (up to a full caseload) in that geographic area to the assigned Social Worker.	6 months (3/31/05)	Intake Supervisors	
1.3.2 10-Day response time of geographic social workers compared to all other 10-Day responses on a monthly basis.	7 months (4/30/05)	Intake Supervisors, Analyst	
1.3.3 Results analyzed. Pilot discontinued or spread to additional Intake Social Workers.	8 months (5/31/05)	Intake Supervisors, Program Managers	

Discuss changes in identified systemic factors needed to further support the improvement goals.
Expanding the use of PDAs, laptops, and quickpads could lead to more timely inputting of contact data.

Describe educational/training needs (including technical assistance) to achieve the improvement goals.
Time management, learning to set priorities.

Identify roles of the other partners in achieving the improvement goals.
Expanded community responsibility and collaboration in the increased delivery of intervention and prevention services will allow for CFS to concentrate more efficiently on tracks that require CFS involvement.

Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals.
Allow the first response that is done by a community agency to count towards the 10 day response timeline if CFS follows up with a contact within a 21 day timeframe.

Outcome/Systemic Factor: Timely Social Worker Visits With Children (2C)

County's Current Performance:

Q4 2003	Oct 2003 80.4%	Nov 2003 83.1%	Dec 2003 82.9%
Q3 2003 (revised)	Jul 2003 83.0%	Aug 2003 82.9%	Sep 2003 82.7%
Q2 2003 (revised)	Apr 2003 85.0%	May 2003 85.9%	Jun 2003 86.1%

Improvement Goal 1.0: Increase the percentage of timely Social Worker and Probation Officer visits with children and timely, accurate documentation in CWS/CMS. Increase County performance to 90% compliance by the end of the first year of the implementation of the System Improvement Plan.

Strategy 1.1: Identify specific causal factors for the County's current level of performance.	**Strategy Rationale:** To determine the percentage of noncompliance attributed to non-contacts versus inaccurate/incomplete documentation in CWS/CMS.

Milestone	Timeframe	Assigned to
1.1.1 Survey developed, conducted, and analyzed to capture causal factors of non-compliant Social Worker visits with children.	1 month (10/31/04)	Treatment Social Workers, CWS/CMS Analyst
1.1.2 If survey indicates a data entry problem, staff will be trained in accurately entering contacts and contact exceptions.	2 months (11/30/04)	CWS/CMS Analyst, Staff Development Supervisor

Strategy 1.2: Develop and institutionalize standard agency guidelines and expectations for the practice of making timely visits with children and accurately and completely documenting contact information and exceptions in CWS/CMS.	**Strategy Rationale:** The accessibility of written guidelines and standard agency expectations will help workers deal with conflicting priorities.

Milestone	Timeframe	Assigned to
1.2.1 Standard agency guidelines and expectations developed for the practice of making *timely* monthly visits with children and *accurately and completely* documenting the contact in CWS/CMS or having visit exceptions approved by a Supervisor and accurately documented in the CWS/CMS case plan.	3 months (12/31/04)	Treatment, Court, Adoptions, and Intake-Voluntary Supervisors and Social Workers, CWS/CMS Analyst, Program Manager.
1.2.2 Guidelines reviewed at Supervisors meeting, revised, and reviewed and accepted by Program Managers.	4 months (1/31/05)	Supervisors, Program Managers
1.2.3 Desk guide developed for guideline, CWS/CMS documentation, and visit exception process and documentation.	5 months (2/28/05)	CWS/CMS Analyst
1.2.4 Social Workers trained on guidelines and standard agency expectations.	6 months (3/31/05)	Staff Development Supervisor, Placement Clerk
1.2.5 Treatment, Court, Adoptions, and Intake-Voluntary Supervisors supervision time used to help Social Workers learn to use guidelines, desk guide, and list of standardized expectations to prioritize workload.	7 – 12 months (4/30/05 – 9/30/05)	Treatment, Court, Adoptions, and Intake-Voluntary Supervisors

Strategy 1. 3: Develop a Quality Assurance procedure and checklists to be used at each unit transition point to ensure contacts are made timely and are accurately and completely documented in CWS/CMS.	**Strategy Rationale:** Checking the quality of Social Work as cases transition through our system will ensure earlier detection of potential problems.

Milestone	Timeframe	Assigned to
1.3.1 Standard agency Quality Assurance procedures developed to ensure that Social Workers are making *timely* monthly visits with children and *accurately and completely* documenting the contact and that appropriate visit exceptions are requested and approved in the CWS/CMS case plan.	5 months (2/28/05)	Treatment, Court, Adoptions, and Intake-Voluntary Supervisors, Placement Clerk, CWS/CMS Analyst
1.3.2 Quality Assurance procedures reviewed at Supervisors meeting, revised, and reviewed and accepted by Program Managers.	6 months (3/31/05)	Supervisors, Program Managers
1.3.3 Case checklist template developed or updated.	7 months (4/30/05)	CWS/CMS Analyst
1.3.4 Social Worker Supervisors and staff trained on Quality Assurance procedures.	8 months (5/31/05)	Staff Development Supervisor, Placement Clerk

Strategy 1. 4: Adopt Safe Measures quality assurance tool for our County.		**Strategy Rationale:** During the piloting of Safe Measures, Social Worker Supervisors and staff were better able to keep track of required monthly visits with children and the correct documentation of exceptions through the use of an automated tool.	
Milestone	**Timeframe**	**Assigned to**	
1.4.1 Cost estimate and plan developed and presented to Director of the Shasta County Department of Social Services.	2 months (11/30/04)	Supervisors, Program Managers, CWS/CMS Analyst, Deputy Director	
1.4.2 Contract established for Safe Measures.	3 months (12/31/04)	CWS/CMS Analyst	
1.4.3 Social Worker Supervisors trained by Safe Measures vendor in use of system for monitoring staff.	4 months (1/31/05)	Vendor, CWS/CMS Analyst	
1.4.4 Progress and successes reported regularly by Supervisors to Program Managers, Deputy Director, and units.	5 – 12 months (2/28/05 – 9/30/05)	Supervisors	

Discuss changes in identified systemic factors needed to further support the improvement goals.
Increasing the number of Case Management Information System portable devices available to Social Workers in the field might improve contact documentation. Funding is needed to purchase and support the Safe Measures tool. Need the ability to expand how other agency and Community Based Organizations visits are entered to CWS/CMS or JLAN system. Need to break down the barriers.

Describe educational/training needs (including technical assistance) to achieve the improvement goals.
Ensuring current CMS and consortium training includes and emphasizes the correct location and manner for data input in CWS/CMS so that outcome data is correctly extracted. Training in the use of the Safe Measures tool.

Identify roles of the other partners in achieving the improvement goals.
For the community based organizations to help change the system and redesign child welfare the community based organizations must be true partners at the table and not just contractors or subcontractors. With the community based organizations we need to develop the communication so that the line Social Workers have confidence in the community based organizations and actually change practice. With the community based organizations we have to build capacity within the community – not just for our agency and our staff. We need the State to broaden the definition of who counts as visits to include community based organizations/providers and medical providers.

Identify any regulatory or statutory changes needed to support the accomplishment of the improvement goals.
Expansion of definition of “staff” allowable to make required contacts. State funded software and quality assurance and monitoring of services.